



Health Standards Section Checklist for Initial Licensing Behavioral Health Service Provider (BHSP)

Application Date:	Opening/Effective Date:
Administrator:	Designated Contact Person:
Designated Contact Person's E-Mail Address:	
Designated Contact Person's Phone:	
BHSP DBA Name:	BHSP email address:
BHSP Entity Name:	
BHSP Address:	
BHSP Phone:	BHSP Fax:
Number of Beds (if applicable) :	

Criteria (Each of these must be attached in order for your application to be processed):	Yes	No	Describe
Letter of Intent (to fully describe the intent of the BHSP, including anticipated date of opening)	<input type="checkbox"/>		
BHSP License Application	<input type="checkbox"/>		
BHSP License Application Fee(s)	<input type="checkbox"/>		
Office of State Fire Marshal LDH Plan Review Approval Letter (will have DH-##-##### project number)	<input type="checkbox"/>		
Cautionary Codes from OSFM	<input type="checkbox"/>		
Attestation for compliance with Plan Review cautionary items (use Cautionary Codes from Plan Review letter)	<input type="checkbox"/>		
Office of State Fire Marshal Certificate for Occupancy Onsite visit **NOT the same as Plan Review above**	<input type="checkbox"/>		
Office of Public Health Certificate for Occupancy Onsite visit	<input type="checkbox"/>		
Floor Plan with Dimensions and Identified Service Areas	<input type="checkbox"/>		
Organizational chart (see webpage)	<input type="checkbox"/>		
If providing addiction services submit copy of Addictionologist's credentials along with written agreement showing their relationship to your program's DBA name	<input type="checkbox"/>		
Criminal Background Checks: Owners, managing employees and those in direct care with under 18	<input type="checkbox"/>		
Line of Credit at least \$50,000 include the official bank statement with last 4 account #####	<input type="checkbox"/>		
General & Professional Liability Insurance at least \$500,000	<input type="checkbox"/>		
Worker's Compensation Insurance	<input type="checkbox"/>		
CLIA certificate (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	
Lease Agreement (if the building is not owned by the BHSP) NOTE: If the BHSP owns the building submit a letter indicating ownership; identify areas that are subleased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If operated by a corporate entity, current proof of registration/status with the La. Secretary of State	<input type="checkbox"/>	<input type="checkbox"/>	

For LDH Use Only	Date	Yes	Comments
Incomplete Packet notice sent to facility			
Fee logged into POPS		<input type="checkbox"/>	
POPS, Add to on- line Activity Report, Logs Updated		<input type="checkbox"/>	
ACO Updated with attachments scanned		<input type="checkbox"/>	
New License Printed/Mailed		<input type="checkbox"/>	
		<input type="checkbox"/>	
application expiration in 90 days / post application approval			
Completed By Program Manager		<input type="checkbox"/>	

HSS-BH-INITIAL Provider Checklist (10/15, 03/16, 02/17, 06/17, 01/19)

Health Standards Section
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